EXHIBIT "3"

P.O. Box 830847
Miami FL 33283-0847

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW
CHECK CARD USING FOR PAYMENT

CARD NUMBER

SIGNATURE | EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
01/06/25	$ 643.20	17173825-1

SHOW AMOUNT PAID HERE $

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

KEN55C 5257219 677680852

Heriberto Valiente
4214 SW 164TH PATH
MIAMI FL 33185-5290

Kendall Credit
and Business Service, Inc.
P.O. Box 404665
Atlanta, GA 30384-4665

0001717382510000064320201007

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

**** Please include your account number on all forms of payment ****

Si necesita una interpretacion de esta carta, por favor comuniquese con nuestra oficina.

PLEASE CALL Darlene Gingras AT (786) 594-6688 EXT. 46666

Creditor: Baptist Hospital
Debtor: Valiente,Heriberto
Account No.: 17173825-1
Service Date: 07/11/24
Amount Due: $643.20

Your Account is long past due and must be paid in full.

As of this date, your debt remains unpaid. We have previously notified you in writing regarding your outstanding debt, yet we have received no resolution from you. Collection efforts will continue until the debt is paid.

Forward payment in full to our office or contact your account representative to make an acceptable payment arrangement.

Do not delay this important matter which requires your attention.

**** Please include your account number on all forms of payment ****

***** To pay online go to: https://billpay.baptisthealth.net *****

Federal law requires us to inform you that this is an attempt to collect a debt and any information obtained will be used for that purpose.

This communication is from a debt collector.

CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION Heriberto Vallente

If you have new health insurance or a new address, please enter the information below. 17173825-1

NEW ADDRESS	CITY	STATE	ZIP CODE
NEW PHONE#		NEW EMAIL ADDRESS	
POLICY HOLDER'S NAME/RELATIONSHIP TO PATIENT		POLICY ID # GROUP #	
EFFECTIVE DATE	BIRTH DATE OF INSURED	HMO/PPO/OTHER	INSURANCE PHONE #
IF GROUP INSURANCE, NAME OF GROUP (EMPLOYER, UNION/ASSOCIATION)			
INSURANCE COMPANY NAME		INSURANCE ADDRESS	
EMPLOYER		EMPLOYER ADDRESS	